Medical and Dental History

Patient Name:____ Date: ______________________

Date of Birth:____/____/____ Race:_______________________ Gender:_________________________

Are you currently under the care of a physician? **YES___** **NO___**

Date of last visit:__________________________ Reason:____

Name of physician:___________________________________ Phone:______________________________

YES NO

☐ ☐ Have there been any changes in your general health in the last year?

☐ ☐ Have you had any serious illness, operation, or been hospitalized in the past 5 years?
If yes, please explain: ____

☐ ☐ Has your physician ever recommended that you take antibiotics prior to dental treatment due to a health condition? If Yes, please explain: ____

☐ ☐ Have you had an orthopedic total joint replacement or heart valve replacement/condition?
Date/Location:____

☐ ☐ Do you have any disability that you will like us to be aware of? Explain:______________________

☐ ☐ Have you ever taken diet pills: If "yes" how long?____

☐ ☐ Have you taken cortisone (steroids) in the last 2 years?

☐ ☐ Have you ever been treated for chemical/alcohol dependency?

☐ ☐ Do you drink alcohol? If so, ☐ 1 drink per day ☐ 2 drinks per day ☐ 3 or more drinks per day ☐ Less than 1 per day

☐ ☐ Do you use recreational (street drugs)? Explain:____

☐ ☐ Have you been diagnosed with diabetes?
Diabetic Status: ☐ Good Diabetic Control ☐ Fair Diabetic Control ☐ Poor Diabetic Control
Date of your last fasting lab_________ Blood sugar level________

☐ ☐ Have you or are you taking blood thinners? When?_____________

☐ ☐ Do you smoke/chew tobacco? Daily Amount____ Number of years____ Date you quit___________

ALLERGIES

Are you allergic or have had any adverse reactions to any of the following?

YES	NO		YES	NO		Other Allergies:
☐	☐	Local Anesthetics	☐	☐	Aspirin	
☐	☐	Codeine or other narcotics	☐	☐	Iodine	________________
☐	☐	Penicillin/Antibiotics	☐	☐	Nickel	________________
☐	☐	Sleeping aid medications	☐	☐	Seasonal Allergies	________________
☐	☐	Sulfa drugs	☐	☐	Latex	

FEMALES ONLY

YES NO

☐ ☐ Post-menopausal or post-hysterectomy

☐ ☐ Are you pregnant? Due Date: _________________

☐ ☐ Are you currently taking birth control mechanism?

☐ ☐ Are you currently breast-feeding?

YES NO CARDIOVASCULAR CONDITIONS

☐ ☐ Angina/Chest Pain/Pain on exertion
☐ ☐ Atherosclerosis/Hardening of Arteries
☐ ☐ Artificial Heart Valve. Date__________
☐ ☐ Internal Defibrillator
☐ ☐ Heart Attack. Date: _______________
☐ ☐ Heart Murmur
☐ ☐ High blood pressure
☐ ☐ Congenital heart defect
☐ ☐ Mitral Valve Prolapse
☐ ☐ Bypass Surgery. Date: ____________
☐ ☐ Pace Maker Date: _______________
☐ ☐ Swelling of Ankles
☐ ☐ Rheumatic Fever/Rheumatic Heart Disease
☐ ☐ Irregular Heart Beat
☐ ☐ Other Heart Conditions. Explain:___________

YES NO RESPIRATORY CONDITIONS

☐ ☐ Tuberculosis
☐ ☐ Persistent Cough /Cough with blood
☐ ☐ Emphysema
☐ ☐ Chronic Bronchitis
☐ ☐ Asthma
☐ ☐ Sinusitis

YES NO GASTROINTESTINAL CONDITIONS

☐ ☐ Colon disorder
☐ ☐ Persistent Diarrhea
☐ ☐ Difficulty Swallowing
☐ ☐ Ulcers
☐ ☐ Malnutrition
☐ ☐ Jaundice
☐ ☐ Gallbladder/Kidney Stones
☐ ☐ Liver Disease/Cirrhosis
☐ ☐ Hepatitis: Please circle type: A B C

YES NO GENITOURINARY CONDITIONS

☐ ☐ Kidney/Bladder Infections
☐ ☐ Dialysis Date: ________

YES NO OTHER CONDITIONS

☐ ☐ Domestic Violence victim
☐ ☐ Glaucoma
☐ ☐ Cold Sores
☐ ☐ Unintended weight loss
☐ ☐ Organ Transplant
☐ ☐ Chronic Pain. Location:_________________

YES NO BONE & JOINT CONDITIONS

☐ ☐ Osteoporosis/osteoarthritis
☐ ☐ Traumatic Injury
☐ ☐ TMJ problems
☐ ☐ Jaw surgery
☐ ☐ Frequent fractures
☐ ☐ Rheumatoid Arthritis
☐ ☐ Joint Replacement. Location/Date: _________

YES NO BLOOD ABNORMALITIES

☐ ☐ Prolonged bleeding
☐ ☐ Anemia
☐ ☐ Sickle cell disease / Trait:________________
☐ ☐ Hemophilia Type: _____________________
☐ ☐ Blood Transfusion Date: _______________

YES NO NEUROLOGICAL CONDITIONS

☐ ☐ Epilepsy
☐ ☐ Convulsions/Seizures
☐ ☐ Stroke
☐ ☐ Neuritis/ Nerve Pain. Location:____________
☐ ☐ Neuralgia/ Facial Pain
☐ ☐ Numbness/ Paralysis
☐ ☐ Severe frequent headaches

YES NO PSYCHOLOGICAL CONDITIONS

☐ ☐ Mental Disability. Explain:_______________
☐ ☐ Depression/ Bipolar
☐ ☐ Anxiety or Panic Disorders
☐ ☐ Eating Disorder, Anorexia, Bulimia
☐ ☐ Other. Explain:_________________________

YES NO IMMUNE CONDITIONS

☐ ☐ AIDS or HIV infections
☐ ☐ Sarcoidosis
☐ ☐ Lupus Erythematosus
☐ ☐ Other Immunodeficiency Disorder

YES NO DERMATOLOGICAL CONDITIONS

☐ ☐ Chronic/ Recurrent Skin Rashes
☐ ☐ Hives
☐ ☐ Psoriasis/ Eczema

YES NO SEXUALLY TRANSMITTED DISEASE

☐ ☐ Type(s):___________________________

YES NO CANCER

☐ ☐ Site:___________ Type:______________
☐ ☐ Chemotherapy/ Radiation. Date:________

LIST OF CURRENT MEDICATIONS

Name of Medications	Dose	Date Started

Purpose of your visit today:____

When was your last dental visit?____

Are you receiving routine dental care: YES___ NO___

Reason for last visit:____

Name of Dentist:____

Have any of the following prevented you from seeking dental care?

- ☐ Fear or Anxiety
- ☐ No transportation
- ☐ Lack of funds/cost
- ☐ No insurance

Have you had any of the following?

- ☐ Orthodontic Treatment (Braces)
- ☐ Oral Surgery
- ☐ Periodontal Treatment. When:______________
- ☐ Injury to jaw, mouth, or head. When:_________

Other Dental Conditions

YES	NO	
☐	☐	Do you have a dry mouth?
☐	☐	Do your gums bleed while brushing/flossing?
☐	☐	Does your jaw click, pop, or cause any discomfort or pain?
☐	☐	Do you grind or clench your teeth?
☐	☐	Have you or do you use a night guard?
☐	☐	Have you noticed any loose teeth?

Hygiene Practices

Are your teeth sensitive to any of the following? ☐ Hot ☐ Cold ☐ Pressure

What type of toothbrush are you using? ☐ Hard ☐ Medium ☐ Soft

How often are you brushing? # times/ day:_______________

How often are you flossing? # times/day:________________

Toothpaste Brand:___________________________________

Do you use daily mouth rinse? ☐ Yes ☐ No

I understand the need for these questions to be answered truthfully. To the best of my knowledge, the answers I have given are accurate. I also understand it is very important to report any changes in my medical or dental status to the dentist at the earliest possible time, and I agree to do so. I have given permission to the dentist to obtain from my physician any additional information regarding my medical or dental history needed to prove me with the best dental treatment possible.

Signature of Patient:____**Date:**_________

If other than the patient, indicate relationship: parent or legal guardian and sign here:____**Date:**_________